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Nos. 84-325, 84-356

IN THE

Supreme Court of the United States

OCTOBER TERM, 1984

METROPOLITAN LIFE INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

THE TRAVELERS INSURANCE COMPANY,
Appellant

v.

COMMONWEALTH OF MASSACHUSETTS,
Appellee

ON APPEALS FROM THE SUPREME JUDICIAL COURT OF MASSACHUSETTS

BRIEF AMICUS CURIAE OF AMERICAN OPTOMETRIC ASSOCIATION IN SUPPORT OF APPELLEE

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The American Optometric Association submits this brief amicus curiae in support of appellee, the Commonwealth of Massachusetts. Letters granting consent, received from counsel of record for each of the parties, have been filed with the Clerk of this Court.

INTEREST OF AMERICAN OPTOMETRIC ASSOCIATION

The American Optometric Association, a nonprofit membership organization incorporated under Ohio law, is a national professional association of more than 25,000 members consisting of licensed Doctors of Optometry, optometry students, and educators. The Association's objects, as set forth in its Constitution, "are to improve the vision care and health of the public and to promote the art and science of the profession of optometry." The Association has as affiliates the state optometric associations in each of the 50 states and in the District of Columbia and the Armed Forces Optometric Society.

As the national professional organization representing the optometric profession, the Association has always been, and is now, vitally interested in matters which affect the adequacy of vision care available to the public. This includes, among other things, its interest in what is called "freedom of choice" legislation—that is, the widely-enacted state legislation which prevents insurance companies or others from discriminating against the practice of optometry and which likewise prevents discrimination against patients who wish to obtain vision care by utilizing the professional services of optometrists instead of physicians for those services within the lawful scope of the practice of optometry. The present cases may have a substantial impact on such matters.

SUMMARY OF ARGUMENT

ERISA has not preempted the mandated benefit provision of Section 47B of Massachusetts General Laws Chapter 175 (which requires that health benefit insurance policies shall include specified minimum benefits for men-

tal and nervous conditions). No such issue was before this Court in *Shaw* v. *Delta Air Lines,* 103 S.Ct. 2890 (1983). Appellants' niggardly interpretation of ERISA's insurance exclusion clause—the clause which excludes from federal preemption "any law of any State which regulates insurance"—is contradicted by the plain meaning of the insurance exclusion clause and its background and by the settled federal policy, manifested particularly in the McCarran-Ferguson Act, of leaving to the states the regulation of insurance.

Appellant insurance companies, and the rest of the insurance industry, cannot rightly rely on ERISA to exempt or relieve them from Massachusetts Section 47B and other comparable state laws regulating insurance; the fair meaning of ERISA's insurance exclusion clause is to prevent just such escapes from being accomplished by the insurance industry.

Furthermore, it is submitted that, in any event, in disposing of these cases the Court should take particular care to avoid any intimation which might impair or cast a cloud on the validity of the widely-enacted state legislation known as "freedom of choice" legislation—which has been enacted in one form or another in nearly all the states. These freedom of choice statutes do not mandate that any particular health coverage be included in health benefit insurance policies or in uninsured employee benefit plans. But they do provide that if certain kinds of treatment (such as vision care) are covered, then such treatment must be covered regardless of the provider of the health services used (that is, in the case of vision care, regardless of whether the professional service is rendered by an optometrist or by a physician). With respect to plans operating through insurance policies, such state regulation is a regulation of insurance and should clearly be sustained under ERISA's insurance exclusion clause.

An additional ground for sustaining such a requirement for an insurance policy is that the freedom of choice statutes do not in any way interfere with or burden the area of federal supremacy which the ERISA regime was intended to establish. This additional ground would also sustain the freedom of choice statutes applicable in a number of states to those employee health benefit plans which do not involve insurance policies but are self-insured or self-funded and hence do not call into play ERISA's insurance exclusion clause. While this issue need not be addressed in these cases, the Court's attention is invited to the fact that the subject may well be involved in future litigation in this Court and that meanwhile it is important that the validity of these state statutory provisions not be impaired.

With respect to appellants' claim that Massachusetts Section 47B has been preempted by the National Labor Relations Act in cases where an employee health benefit plan is the outgrowth of collective bargaining, that claim has been adequately answered by the opinion of the Supreme Judicial Court of Massachusetts and is also being amply dealt with by the appellee's brief on the merits.

ARGUMENT IN SUPPORT OF AFFIRMANCE

The American Optometric Association has a strong interest in the disposition which the Court makes of these two cases.

The cases involve an important controversy as to whether federal law has preempted Section 47B of Massachusetts General Laws Chapter 175 which, as authoritatively interpreted by the Supreme Judicial Court of Massachusetts, expressly requires that insurance policies affording health benefits to Massachusetts

residents shall include specified minimum benefits for the care of mental and nervous conditions. There is no merit in appellants' claim that federal legislation precludes the application of Massachusetts Section 47B to insurance contracts covering Massachusetts residents.

Appellants, Metropolitan Life Insurance Company and The Travelers Insurance Company, are both engaged in the insurance business on a nationwide scale, including the business of writing health insurance policies on a group basis for employee benefit plans. Some of these insurance policies cover multi-state groups; many do not. The trial court's findings show that, at that time, over 140,000 employees residing in Massachusetts were known to be included in the employee health benefit insurance policies written by the two appellants alone (J.S.App. in No. 84-325 at 40a-42a), apart from the vast numbers of Massachusetts residents who are covered by such policies issued by other insurance companies. These circumstances underscore the reasons why Massachusetts has such a legitimate special concern to prevent the insurance industry from escaping the reach of a statute regulating insurance which Massachusetts has enacted in order to implement significant public policies of the Commonwealth.

The principal issue in these two cases turns on the fair scope of the preemption provisions in the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, and of the express exclusions from preemption which Congress likewise provided for in that Act.[1] In Section 514(a) of ERISA, 29 U.S.C. § 1144(a),

[1]A secondary claim made by the appellants is that, in situations where the health insurance policy for the particular employee benefit plan has resulted from collective bargaining, application of the Massachusetts statute is preempted by the National Labor Relations

Congress included the following provision as to preemption:

> "(a) Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title."

One of the areas expressly excluded from such preemption, however, is "any law of any State which regulates insurance." This appears in Section 514(b) of ERISA, 29 U.S.C. § 1144(b), which provides in part that:

> "(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

Act, 29 U.S.C. §§ 151 *et seq.* The claim is developed, on behalf of both appellants, in the brief filed by appellant Travelers in No. 84-356. The claim appears to be nothing more than an unwarranted attempt at far-fetched extrapolation from this Court's rulings in *Teamsters* v. *Oliver*, 358 U.S. 283 (1959) and *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525-526 (1981). The total lack of substance to any such claim of NLRA preemption is demonstrated by the first opinion of the Supreme Judicial Court of Massachusetts in the present litigation (385 Mass. at , 433 N.E.2d at 1230-1233; see J.S. App. in No. 84-325 at 25a-31a), and is also, we understand, being amply dealt with in the brief on the merits being filed by the appellee, the Commonwealth of Massachusetts. Indeed, even the AFL-CIO, which has filed a brief amicus curiae supporting appellants' position on ERISA preemption, has felt compelled to voice its doubts (see AFL-CIO Br. at 5-6, note 1) concerning appellants' claim under the National Labor Relations Act.

Despite the fact that Metropolitan Life and Travelers are "persons" and are undeniably in the insurance business, despite the fact that the Massachusetts statute here in issue regulates the substantive contents of the health benefit insurance policies which appellants and other insurance companies may issue for coverage of Massachusetts residents, despite the fact that Massachusetts (like many other states) has a long tradition of regulating the substantive contents of insurance policies which an insurance company is permitted to issue,[2] the appellants nevertheless contend that ERISA's preemption provision has, in some magic fashion, operated to exempt and relieve the insurance industry from the operation of Massachusetts Section 47B whenever the insurance policy is tied in with an employee benefit plan. This, it is contended by appellants and by those amicus curiae briefs filed in support of appellants, follows from the analysis made by this Court in *Shaw* v. *Delta Air Lines,* 103 S.Ct. 2890 (1983), and from the emphasis in that opinion on the breadth of ERISA's preemption provision which had as an objective the giving of reasonable encouragement to uniformity in multi-state employee benefit plans.

But nothing in *Shaw* can possibly justify the niggardly interpretation which appellants would here impose on ERISA's insurance exclusion clause. The insurance exclusion clause was not at all before this Court in *Shaw* (as appellant Metropolitan Life acknowledges, Br. 19); it is now. It comes buttressed by a well-considered opinion of the Supreme Judicial Court of Massachusetts to the effect that, giving full range to *Shaw,* the applicability of the Massachusetts statute remains valid as a regulation of in-

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[2]See the Massachusetts statutory provisions dating back at least to 1908 referred to in the Commonwealth's Motion to Dismiss or Affirm, filed October 5, 1984, at 21-22, note 8.

surance from which insurance companies are not exempted or relieved by ERISA. It involves a plain meaning—a principle of interpretation only the other day once more reaffirmed by this Court in *Garcia* v. *United States,* 105 S.Ct. 479, 482-483 (1984). There is nothing in the legislative history to contradict this plain meaning or to show that Congress had the slightest intention in 1974 to preempt state statutes which regulate insurance by requiring insurance companies to include certain minimum benefits in employee health insurance policies. Instead, there is an utter silence in the legislative history which appellant Metropolitan Life (Br. 37-38) seeks painfully to explain away.

Moreover, our view of the scope of ERISA's insurance exclusion clause is further buttressed by the well-known provisions in the McCarran-Ferguson Act, 15 U.S.C. §§ 1012(a) and (b), enacted in 1945, that "The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business," and that "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance,[3] . . . unless such Act specifically relates to the business of insurance. . . ." Particularly in the present circumstances, this expression of

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[3]*Compare Group Life & Health Ins. Co.* v. *Royal Drug Co.,* 440 U.S. 205, 215-216 (1979), stating:

> "Another commonly understood aspect of the business of insurance relates to the contract between the insurer and the insured. In enacting the McCarran-Ferguson Act Congress was concerned with:
>
> 'The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement—these were the core of the "business of insurance."' "

basic federal policy cannot be squared with appellants' efforts to escape the reach of Massachusetts Section 47B.

If this means that insurance companies are at some disadvantage, as against self-insured or self-funded plans, in competing for the business of employee benefit plans, the reason is that Congress deliberately chose to exclude from ERISA's preemption provision "any law of any State which regulates insurance." Faced with the need to balance the federal interest in encouraging the possibilities of uniformity for multi-state employee benefit plans as against the strong federal policy to leave the regulation of insurance to the states, Congress made a choice in favor of preserving the established rights of the states to regulate insurance. If the insurance industry or their supporters are dissatisfied with that resolution of the matter, their remedy would lie in an appeal to Congress, *compare Arizona* v. *Maricopa County Medical Society,* 457 U.S. 332, 354-355 (1982)—and perhaps they perceive the present Congress would not be very likely to shift from the choice an earlier Congress made when ERISA was enacted in 1974.

The present cases involve a particular mandated benefit which Massachusetts requires the insurance companies to offer with respect to the care of mental and nervous conditions. For the reasons we have summarized, and which are more fully developed both in the opinion of the Massachusetts Supreme Judicial Court and in the Commonwealth's brief as appellee, the Massachusetts statutory requirement that the insurance companies must include such a benefit in their health insurance policies should be sustained.

Similarly, if Massachusetts or some other state were to enact legislation that certain minimum vision care benefits

must be included in employee health insurance policies, it is the position of the American Optometric Association that such a mandated benefit provision should be sustained against comparable attack. We add, however, that we are not aware that any state presently has on its books a mandated benefit with respect to vision care. What is on the books is a vast body of state legislation, enacted in one form or another in about 48 states, which is known as "freedom of choice" legislation and which safeguards a patient's freedom of choice to select a provider of a particular health care service. With respect to vision care coverage which is provided for by an employee benefit plan, this means that the statutes of nearly all the states call for the reimbursement of the patient who utilizes the professional services of either an optometrist or a physician as long as the services performed come within what may lawfully be performed by a licensed optometrist under the laws of the particular state.

To assist the Court in its consideration of issues addressed by other briefs in the present cases, we invite the Court's attention to this vast body of state legislation and to its true nature. Appellant Metropolitan Life (Br. 3-4, note 5) discusses the variety of mandated benefit statutes—that is, state laws requiring health benefit insurance policies to provide coverage for a particular illness or condition—and refers also to the list of such mandated benefit statutes which Metropolitan Life cited at the jurisdictional statement stage (J.S. in No. 84-325 at 8-9, note 5)—none of which statutes involves mandated vision care.[4]

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[4]Metropolitan Life also (Br. 4, note 5) refers to the survey of state statutes which had been submitted as an appendix to the brief amicus curiae filed September 29, 1984, by the Health Insurance Association of America at the jurisdictional statement stage. That Health In-

Metropolitan Life correctly says (Br. 4, note 5) that "only mandated benefit statutes are at issue on this appeal"—and not those state statutes which specify that if certain kinds of treatment are covered by health insurance benefit policies, then such treatment must be covered regardless of the provider of the health services selected.

These latter are the freedom of choice statutory provisions which, as we have noted, have been enacted in nearly all the states to prevent discrimination in insurance policies against the utilization of the professional services of optometrists for vision care. These freedom of choice statutes represent deep-rooted policies of the states concerned. They are aimed at protecting the residents of the

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surance Association brief in its Appendix IIA (at 3a), classifying mandated benefits by subject matter, correctly does not list vision care as a mandated benefit required by any state. However, its Appendix IIB (at 4a) may be inadvertently but distinctly misleading. It is entitled "State Laws Affecting Group Health Insurance Coverage for Services Rendered by a Particular Type of Health Care Provider." On the line for "Optometrist" it gives the figure "37" (meaning 37 states) in the column "Coverage Must Be Included in Group Policies" and the figure "2" in the column "Coverage Must Be Offered to Group Purchasers" and the figure "39" in the "Total" column. Then in Appendix III (at 5a-16a) these statutes are identified by state code citations and are listed by check marks under the column head "Must Be Included" or "Must Be Offered." (We accept the citations as being substantially accurate, although somewhat incomplete, and hence do not duplicate them by compiling an appendix of our own.) The net impression left on a reader who examines the Health Insurance Association tables might well be that these statutes generally mandate that health benefit insurance policies shall provide vision care benefits and that in order for such benefits to be obtained the services of an optometrist must be used. The actuality is quite different. The statutes do not mandate that vision care benefits shall be provided at all; instead they require in substance that whenever vision care benefits are provided, then the individual shall have freedom of choice to select either an optometrist or a physician with respect to any professional service which an optometrist may lawfully perform under the laws of the state.

states by assuring that more widespread vision care is available, by safeguarding the patient's freedom of choice, and indeed by discouraging monopolistic or restrictive practices by insurance companies and others which would tend to channel away from optometrists and to physicians the performance of vision care services which otherwise would flow to optometrists. *Compare Blue Shield of Virginia* v. *McCready,* 457 U.S. 465 (1982). Some of these statutes regulating insurance policies will be found in the portions of the state codes which deal with insurance; some will be found elsewhere. But wherever they are located in the state code, to the extent that they govern the provisions of health insurance benefit policies which may be written by insurance companies, they in any event come within the insurance exclusion clause of ERISA as a law "which regulates insurance" and hence on that ground alone are valid and not preempted by ERISA.[5]

There is also an additional ground, apart from ERISA's insurance exclusion clause, on which the American Optometric Association submits that the freedom of choice statutes should be sustained. This additional ground is that the nature of the freedom of choice statutes is not such that they burden the area of federal supremacy which the ERISA regime was intended to establish. *Compare Terminal Ass'n* v. *Trainmen,* 318 U.S. 1, 6-7 (1943); *Pacific Gas & Electric* v. *State Energy Resources Commission,* 103 S.Ct. 1713 (1983); *Arkansas Elec. Co-Op Corp.* v. *Arkansas Public Com'n,* 103 S.Ct. 1905 (1983). The state freedom of choice statutes do not impose on the par-

[5]With respect to any employee benefit plan which is the product of a collective bargaining agreement (see note 1, *supra*), we submit that any contention that a state freedom of choice statute has been preempted by the National Labor Relations Act would be wholly implausible and frivolous.

ties a substantive health coverage which the parties wish to avoid contracting for. Instead, the statutes assure that if vision care coverage is in fact contracted for, then there shall be no discrimination against persons who obtain such vision care by using the professional services of optometrists instead of physicians. The preemption issues which this Court canvassed in *Shaw* did not involve any such question; the question is not directly raised by the present cases which involve mandated benefits; and if it ever does come before the Court in some subsequent case, then there would be ample opportunity to develop the significant differences between the issues it raises and the issues which *Shaw* actually addressed.

This additional ground is of especial importance because some of the state legislation applies the freedom of choice principle to employee health benefit plans which are not incorporated into insurance policies written by insurance companies and to which the insurance exclusion clause of ERISA accordingly would not be germane. With respect to optometry, the freedom of choice legislation is applicable to non-insured plans (that is, to what are variously called self-insured or self-funded plans) in a number of states. For reasons we have indicated, it is the American Optometric Association's position that such freedom of choice legislation—which clearly was not before this Court in *Shaw*—was not preempted by ERISA and remains a valid exercise of state power for the implementation of important public policies of the states concerned.

It should be noted, moreover, that a considerable segment of the state freedom of choice legislation relating to vision care—some of it pertaining to insured plans only, some of it pertaining to plans not incorporated into insurance policies, and some of it pertaining to both—was

enacted during the 1960s, long before ERISA was passed in 1974.[6] Hence the total absence, in ERISA's legislative history, of any suggestion that Congress intended to preempt this well-known mass of freedom of choice legislation adds much weight to the other reasons for concluding that no such preemption has occurred.

We urge that in its disposition of the present cases the Court, in any event, should avoid any intimation which might impair or cast a cloud on the validity of the widely-adopted state freedom of choice legislation.

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[6]Such freedom of choice legislation relating to vision care dating from the 1960s is to be found in at least 24 states—namely, Alabama, Arizona, California, Colorado, Hawaii, Idaho, Indiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, New Hampshire, New Jersey, North Carolina, Oklahoma, Oregon, South Dakota, Tennessee, Utah, Washington, West Virginia—and from 1970 through 1973 in at least 10 additional states—namely, Arkansas, Florida, Kansas, Kentucky, Louisiana, Missouri, Nevada, New Mexico, New York, Virginia. (This is apart from the considerable body of freedom of choice legislation dating from those periods and relating to branches of health care other than vision care.) Accordingly, much of the freedom of choice legislation not only antedates the enactment of ERISA in 1974, but will be found well before March 1970. We mention March 1970 as a line of demarcation only because appellant Metropolitan Life (Br. 37, note 15), in its tortured effort to explain away the negatives and the silences confronting it in ERISA's legislative history with respect to mandated benefits, claims March 1970 as the date when the insurance exclusion clause first made its appearance in one of the predecessor bills which was not passed. Metropolitan Life, asserting that no mandated benefit statutes existed before March 1970, then contends (Br. 37-38) that the silence on the subject in the subsequent legislative history should be ignored. Even if the argument were meritorious — which we submit it clearly is not—it could not explain away the total lack of any manifested intention to preempt the freedom of choice statutes which were so widespread and so well-publicized before the March 1970 date.

CONCLUSION

The judgment of the Supreme Judicial Court of Massachusetts was correct and should be affirmed.

Respectfully submitted,

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